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377 Sylvan Lake Road
Eagle, CO 81631
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Colorado Mountain Medical, PC

Stephen P. Laird, MD, MS

Gastroenterology and Hepatology

MR#_____

PATIENT INFORMATION SHEET

NAME_____ SEX: M F DOB: _____ AGE: ____ DATE: _____

MARITAL STATUS: SINGLE___ MARRIED___ DIVORCED___ WIDOWED___ NUMBER OF CHILDREN: _____

PRIMARY CARE PHYSICIAN _____

It is important for our physicians/PAC to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical records.

PAST SURGICAL AND MEDICAL HISTORY - (Circle Yes or No) If yes, date of onset, comments.

MEDICAL HISTORY	YES	NO	Onset, Comments	SURGICAL HISTORY	YES	NO	Date, Comments
Anorexia / Bulemia	YES	NO		Colon	YES	NO	
Arthritis / Joint Swelling	YES	NO		Stomach	YES	NO	
Asthma	YES	NO		**Heart:**	YES	NO	
Bleeding Disorder	YES	NO		Stent / Bypass	YES	NO	
Blood or Infectious Disease	YES	NO		Valve	YES	NO	
Cancer, Type:	YES	NO		Pacemaker	YES	NO	
Colon polyps	YES	NO		Defibrillator	YES	NO	
Crohn's Disease	YES	NO		Joint Replacement	YES	NO	
Diabetes	YES	NO		Gallbladder	YES	NO	
Epilepsy / Seizures	YES	NO		Hysterectomy	YES	NO	
Gallstones	YES	NO		Appendix	YES	NO	
Glaucoma	YES	NO		Prostate	YES	NO	
Headaches / Fainting / Dizziness	YES	NO		Bladder	YES	NO	
Heart Problems / Chest Pain	YES	NO		C-Section	YES	NO	
Hepatitis / Liver Problems	YES	NO		Breast	YES	NO	
Hiatal Hernia / GERD	YES	NO		Other Surgeries			
High / Low Blood Pressure	YES	NO		Other Surgeries			
Kidney Disease	YES	NO		Other Surgeries			
Lung Disease	YES	NO		Other Surgeries			
Pacemaker / Internal Defibrillator	YES	NO		Anesthesia Problems	YES	NO	
Sleep Apnea	YES	NO		Previous EGD	YES	NO	
Stomach Problems / Ulcers	YES	NO		Previous Colonoscopy	YES	NO	
Stroke	YES	NO		**Vaccinations (Yes or No, and date)**			
Thyroid Problems	YES	NO		Hepatitis A	YES	NO	
Tuberculosis	YES	NO		Hepatitis B	YES	NO	
Ulcerative Colitis	YES	NO					
Other							
Other							
Other							

CURRENT MEDICATIONS: Please include vitamins, herbs and pain relievers **AND RECENT ANTIBIOTICS**

Medication	Dosage	Times per Day	Medication	Dosage	Times per Day

ALLERGIES	REACTION	ALLERGIES	REACTION	ALLERGIES	REACTION

OVER PLEASE

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NAME_____ SEX: M F DOB: _____ AGE: _____ DATE: _____

SOCIAL HISTORY: (PAST OR CURRENT)	**YES**	**NO**		
Alcohol	YES	NO	Quit	Duration & Amount
Coffee / Caffeine	YES	NO	Quit	Duration & Amount
Substance Abuse	YES	NO	Quit	Duration & Amount
Tobacco	YES	NO	Quit	Duration & Amount
Blood Transfusions	YES	NO	When?	
Tattoos	YES	NO		
Do you exercise	YES	NO	How Much?	
FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.				
Alcoholism	YES	NO		
Cirrhosis / Jaundice	YES	NO		
Colon Cancer	YES	NO		
Colon or Rectal Polyps	YES	NO		
Crohn's / Ulcerative Colitis	YES	NO		
Diabetes	YES	NO		
Gallstones	YES	NO		
Hemachromatosis	YES	NO		
Heart Disease	YES	NO		
High Blood Pressure	YES	NO		
Liver Disease	YES	NO		

SYMPTOM REVIEW: Check (X) symptoms you currently have or have had in the past

❑ Weight Loss	❑ Cough	❑ Frequent Urination	❑ Memory Loss
❑ Fever / Chills	❑ Shortness of Breath	❑ Incontinence of Urine	❑ Depression
❑ Poor Vision / Double Vision	❑ Heartburn	❑ Difficulty Urinating	❑ Anxiety
❑ Dry Mouth	❑ Nausea / Vomiting	❑ Blood in Urine	❑ Hair Loss
❑ Frequent Nosebleeds	❑ Swallowing Difficulties	❑ Arthritis / Joint Pain	❑ Hot / Cold Sensitivity
❑ Hearing Loss	❑ Pain with Swallowing	❑ Muscle Aches	❑ Excessive Thirst
❑ Nasal Congestion	❑ Abdominal Pain	❑ New or Chronic Rash	❑ Easy Bruising
❑ Hoarseness	❑ Diarrhea	❑ Nail Changes	❑ Excessive Bleeding
❑ Chest Pain	❑ Constipation	❑ Headaches	❑ Swollen Lymph Nodes
❑ Irregular Heart Beat	❑ Blood in Stool	❑ Seizures	❑ Swelling of Ankles / Legs

OTHER

OTHER

Physician notes if needed:

OTHER PHYSICIANS WHO ARE ACTIVELY TREATING YOU:	
Doctor:	Condition:
Doctor:	Condition:

REVIEWED BY: **DATE:**

IF THIS FORM WAS FILLED OUT MORE THAN 30 DAYS AGO, PATIENT AND PHYSICIAN WILL REVIEW AND UPDATE:

Patient Signature:	Physician Signature:	Date:	❑ No Changes ❑ Changes Made
Patient Signature:	Physician Signature:	Date:	❑ No Changes ❑ Changes Made

Physician / PAC Signature: